

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only	1. ☒ Electronically prepared cost report Date: 05/14/2021 Time: 15:16 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VAN MATRE ENCOMPASS HEALTH REHABILIT (14-3028) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2020 and ending 12/31/2020, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☒ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) ROB WISNER
Chief Financial Officer or Administrator of Provider(s)

SVP REIMBURSEMENT
Title

05/14/2021 15:16
Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		123,864			-39,354	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		123,864			-39,354	200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 950 SOUTH MULFORD ROAD	P.O. Box:		1
2	City: ROCKFORD	State: IL	ZIP Code: 61108	County: WINNEBAGO

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	VAN MATRE ENCOMPASS HEALTH REHABILIT	14-3028	40420	5	04 / 12 / 2002	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01 / 01 / 2020	To: 12 / 31 / 2020	20
21	Type of control (see instructions)	5		21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	281	334	113		2,297		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)			37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

	Teaching Hospitals	1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter 'Y' for yes or 'N' for no in column 2.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	NAHE MA Y/N 2	3	
60	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter 'Y' for yes or 'N' for no in column 2.	N			60
		1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4 direct the GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)			62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N		63
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WORKSHEET S-2 PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N		76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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WORKSHEET S-2 PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	Y	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes or 'N' for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter 'Y' for yes or 'N' for no in column 2. (see instructions)					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109

				1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110
			1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.		N		111
			1	2	3
112	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.		N		112

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	46,864	168,640		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N		120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	Removed and reserved			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	HB1911	140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: ENCOMPASS HEALTH	Contractor's Name: PALMETTO	Contractor's Number: 10111	141
142	Street: 9001 LIBERTY PARKWAY	P.O. Box:		142
143	City: BIRMINGHAM	State: AL	ZIP Code: 35242	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N					165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)						166
	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2 PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/26/2021	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/04/2021	N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	31

Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information			
41	First name: ELIZABETH	Last name: HENDERSON	Title: REIMBURSEMENT ACCOUNTANT
42	Employer: ENCOMPASS HEALTH		
43	Phone number: 2059705848	E-mail Address: ELIZABETH.HENDERSON@ENCOMPASSHEALTH.	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Hospital Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	65	23,790			10,220	381	19,523	1
2	HMO and other (see instructions)						3,395	2,644		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		65	23,790			10,220	381	19,523	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		65	23,790			10,220	381	19,523	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		65							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					777	31	1,468	1
2	HMO and other (see instructions)					244	198		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		175.36			777	31	1,468	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		175.36						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1 Total salaries (see instructions)	200	12,494,708			364,737.46		1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetest Part B							3
4 Physician-Part A - Administrative							4
4.01 Physician-Part A - Teaching							4.01
5 Physician-Part B							5
6 Non-physician-Part B							6
7 Interns & residents (in an approved program)	21						7
7.01 Contracted interns & residents (in an approved program)							7.01
8 Home office and/or related organization personnel							8
9 SNF	44						9
10 Excluded area salaries (see instructions)			119,732		2,758.03		10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		1,055			17.29		11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative		191,850			1,295.00		13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries		700,391			10,409.24		14.01
14.02 Related organization salaries							14.02
15 Home office: Physician Part A - Administrative							15
16 Home office & Contract Physicians Part A - Teaching							16
16.01 Home office Physicians Part A - Teaching							16.01
16.02 Home office contract Physicians Part A - Teaching							16.02
WAGE-RELATED COSTS							
17 Wage-related costs (core)(see instructions)		2,613,567					17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		25,287					19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B							21
22 Physician Part A - Administrative							22
22.01 Physician Part A - Teaching							22.01
23 Physician Part B							23
24 Wage-related costs (RHC/FQHC)							24
25 Interns & residents (in an approved program)							25
25.50 Home office wage-related		315,588					25.50
25.51 Related organization wage-related							25.51
25.52 Home office: Physician Part A - Administrative - wage-related							25.52
25.53 Home office: Physicians Part A - Teaching - wage-related (core)							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department							26
27 Administrative & General		2,076,007	-119,732		42,273.97		27
28 Administrative & General under contract (see instructions)		12,706			147.08		28
29 Maintenance & Repairs							29
30 Operation of Plant		246,959			6,468.80		30
31 Laundry & Linen Service							31
32 Housekeeping		112,228			7,883.20		32
33 Housekeeping under contract (see instructions)							33
34 Dietary		371,989			19,302.40		34
35 Dietary under contract (see instructions)							35
36 Cafeteria							36
37 Maintenance of Personnel							37
38 Nursing Administration		743,259			19,240.00		38
39 Central Services and Supply							39
40 Pharmacy							40
41 Medical Records & Medical Records Library		90,814			3,910.40		41
42 Social Service		389,576			12,022.40		42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		12,507,414		12,507,414	364,884.54	34.28	1
2	Excluded area salaries (see instructions)			119,732	119,732	2,758.03	43.41	2
3	Subtotal salaries (line 1 minus line 2)		12,507,414	-119,732	12,387,682	362,126.51	34.21	3
4	Subtotal other wages & related costs (see instructions)		893,296		893,296	11,721.53	76.21	4
5	Subtotal wage-related costs (see instructions)		2,929,155		2,929,155		23.65%	5
6	Total (sum of lines 3 through 5)		16,329,865	-119,732	16,210,133	373,848.04	43.36	6
7	Total overhead cost (see instructions)		4,043,538	-119,732	3,923,806	111,248.25	35.27	7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3 PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	189,945	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,582,893	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	14,612	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	380,334	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	890,669	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	36,253	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances	-455,852	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	2,638,854	24

Part B - Other Than Core Related Cost

25	Other Wage Related Costs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3
PART V****Part V - Contract Labor and Benefit Cost****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	192,905	2,638,854	1
2	Hospital	192,905	2,613,567	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other		25,287	18

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,005,545	1,005,545	203,534	1,209,079	100,442	1,309,521	1
2	00200	Cap Rel Costs-Mvble Equip		506,905	506,905	53,085	559,990	-6,482	553,508	2
3	00300	Other Cap Rel Costs		249,492	249,492	-249,492			-0-	3
4	00400	Employee Benefits Department		2,481,209	2,481,209		2,481,209	141,976	2,623,185	4
5	00500	Administrative & General	2,076,007	3,474,700	5,550,707	-178,844	5,371,863	-514,682	4,857,181	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	246,959	574,424	821,383	-14,138	807,245	-134,589	672,656	7
8	00800	Laundry & Linen Service		138,664	138,664		138,664		138,664	8
9	00900	Housekeeping	112,228	63,370	175,598		175,598		175,598	9
10	01000	Dietary	371,989	369,728	741,717		741,717	-8,756	732,961	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	743,259	7,414	750,673		750,673	-500	750,173	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	90,814	562	91,376		91,376		91,376	16
17	01700	Social Service	389,576	12,721	402,297		402,297	-225	402,072	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	4,861,500	43,464	4,904,964	511,350	5,416,314	-14,656	5,401,658	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		195,557	195,557	-112,260	83,297	-4,521	78,776	54
54.01	05401	RADIOLOGY-SUA				100,190	100,190	-4,750	95,440	54.01
60	06000	Laboratory		686,034	686,034	219,912	905,946	-374,026	531,920	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	347,286	14,821	362,107		362,107		362,107	65
66	06600	Physical Therapy	1,355,761	32,740	1,388,501	-59,687	1,328,814		1,328,814	66
67	06700	Occupational Therapy	1,057,781	5,116	1,062,897	47,059	1,109,956		1,109,956	67
68	06800	Speech Pathology	360,970	5,466	366,436	12,628	379,064		379,064	68
71	07100	Medical Supplies Charged to Patients	28,887	498,509	527,396	-118,274	409,122	-48	409,074	71
73	07300	Drugs Charged to Patients	451,691	556,299	1,007,990		1,007,990		1,007,990	73
76.01	03951	SPECIAL PROCEDURES		541,964	541,964	-538,081	3,883		3,883	76.01
76.02	03952	SPECIAL PROCEDURES - SUA				1,851	1,851		1,851	76.02
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency		90	90	-90				101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		5,948	5,948		5,948	-5,948		113
118		SUBTOTALS (sum of lines 1-117)	12,494,708	11,470,742	23,965,450	-121,257	23,844,193	-826,765	23,017,428	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
194	07951	NRCC MARKETING				121,259	121,259		121,259	194
194.01	07952	NRCC GUEST MEALS								194.01
194.10	07960	OTHER NRCC		2	2	-2				194.10
200		TOTAL (sum of lines 118-199)	12,494,708	11,470,744	23,965,452		23,965,452	-826,765	23,138,687	200

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		5,652	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		1,475	2
3	INSURANCE	A					3
500	Total reclassifications					7,127	500
	Code Letter - A						
1	MARKETING	B	NRCC MARKETING	194	119,732	1,527	1
2	MARKETING	B					2
500	Total reclassifications				119,732	1,527	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		50,550	1
2	PHYSICIANS	C					2
500	Total reclassifications					50,550	500
	Code Letter - C						
1	SERVICE UNDER ARRANGEMENT	D	RADIOLOGY-SUA	54.01		100,190	1
2	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES - SUA	76.02		1,851	2
3	SERVICE UNDER ARRANGEMENT	D					3
4	SERVICE UNDER ARRANGEMENT	D					4
500	Total reclassifications					102,041	500
	Code Letter - D						
1	DEPT 283 RECLASS	E	Occupational Therapy	67	46,875	184	1
2	DEPT 283 RECLASS	E	Speech Pathology	68	12,579	49	2
3	DEPT 283 RECLASS	E					3
500	Total reclassifications				59,454	233	500
	Code Letter - E						
1	OXYGEN RECLASS	F	Medical Supplies Charged to P	71		14,138	1
2	OXYGEN RECLASS	F					2
500	Total reclassifications					14,138	500
	Code Letter - F						
1	ACCOUNT 6530 RECLASS	G	Adults & Pediatrics	30		132,412	1
2	ACCOUNT 6530 RECLASS	G					2
500	Total reclassifications					132,412	500
	Code Letter - G						
1	RECLASS TO CMS 5	H	Administrative & General	5		92	1
2	RECLASS TO CMS 5	H					2
3	RECLASS TO CMS 5	H					3
500	Total reclassifications					92	500
	Code Letter - H						
1	RECLASS 76.01 DIALYSIS TO CMS 6	I	Laboratory	60		207,842	1
2	RECLASS 76.01 DIALYSIS TO CMS 6	I					2
500	Total reclassifications					207,842	500
	Code Letter - I						
1	RECLASS 54 CONTRACT LAB TO 60	J	Laboratory	60		12,070	1
2	RECLASS 54 CONTRACT LAB TO 60	J					2
500	Total reclassifications					12,070	500
	Code Letter - J						
1	DEPT 775 EXPENSE RECLASS	K	Adults & Pediatrics	30		328,388	1
2	DEPT 775 EXPENSE RECLASS	K					2
500	Total reclassifications					328,388	500
	Code Letter - K						
	GRAND TOTAL (Increases)				179,186	856,420	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		7,127		3
500	Total reclassifications					7,127		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	119,732	1,527		2
500	Total reclassifications				119,732	1,527		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		50,550		2
500	Total reclassifications					50,550		500
	Code letter - C							
1	SERVICE UNDER ARRANGEMENT	D						1
2	SERVICE UNDER ARRANGEMENT	D						2
3	SERVICE UNDER ARRANGEMENT	D	Radiology-Diagnostic	54		100,190		3
4	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES	76.01		1,851		4
500	Total reclassifications					102,041		500
	Code letter - D							
1	DEPT 283 RECLASS	E						1
2	DEPT 283 RECLASS	E						2
3	DEPT 283 RECLASS	E	Physical Therapy	66	59,454	233		3
500	Total reclassifications				59,454	233		500
	Code letter - E							
1	OXYGEN RECLASS	F						1
2	OXYGEN RECLASS	F	Operation of Plant	7		14,138		2
500	Total reclassifications					14,138		500
	Code letter - F							
1	ACCOUNT 6530 RECLASS	G						1
2	ACCOUNT 6530 RECLASS	G	Medical Supplies Charged to P	71		132,412		2
500	Total reclassifications					132,412		500
	Code letter - G							
1	RECLASS TO CMS 5	H						1
2	RECLASS TO CMS 5	H	Home Health Agency	101		90		2
3	RECLASS TO CMS 5	H	OTHER NRCC	194.10		2		3
500	Total reclassifications					92		500
	Code letter - H							
1	RECLASS 76.01 DIALYSIS TO CMS 6	I						1
2	RECLASS 76.01 DIALYSIS TO CMS 6	I	SPECIAL PROCEDURES	76.01		207,842		2
500	Total reclassifications					207,842		500
	Code letter - I							
1	RECLASS 54 CONTRACT LAB TO 60	J						1
2	RECLASS 54 CONTRACT LAB TO 60	J	Radiology-Diagnostic	54		12,070		2
500	Total reclassifications					12,070		500
	Code letter - J							
1	DEPT 775 EXPENSE RECLASS	K						1
2	DEPT 775 EXPENSE RECLASS	K	SPECIAL PROCEDURES	76.01		328,388		2
500	Total reclassifications					328,388		500
	Code letter - K							
	GRAND TOTAL (Decreases)				179,186	856,420		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	15,880					15,880		2
3	Buildings and Fixtures	3,577,521				1,263	3,576,258		3
4	Building Improvements	14,275,441	57,229		57,229	6,000	14,326,670		4
5	Fixed Equipment	4,357,689	478,796		478,796	163,034	4,673,451		5
6	Movable Equipment								6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	22,226,531	536,025		536,025	170,297	22,592,259		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	22,226,531	536,025		536,025	170,297	22,592,259		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	826,413	179,132					1,005,545	1
2	Cap Rel Costs-Mvble Equip	339,716	167,189					506,905	2
3	Total (sum of lines 1-2)	1,166,129	346,321					1,512,450	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	17,918,808		17,918,808	0.793139		197,882		197,882	1
2	Cap Rel Costs-Mvble Equip	4,673,451		4,673,451	0.206861		51,610		51,610	2
3	Total (sum of lines 1-2)	22,592,259		22,592,259	1.000000		249,492		249,492	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	912,928	1,430	191,629	5,652	197,882		1,309,521	1
2	Cap Rel Costs-Mvble Equip	333,234	167,189		1,475	51,610		553,508	2
3	Total (sum of lines 1-2)	1,246,162	168,619	191,629	7,127	249,492		1,863,029	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-14,656				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	720,796				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-5,948	Interest Expense	113	11	37
37.02	DEPRECIATION	A	1,032	Cap Rel Costs-Mvble Equip	2	9	37.02
37.03	INSURANCE	A	148,055	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-267,974	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-38,248	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-3,024	Operation of Plant	7		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-296	Dietary	10		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-500	Nursing Administration	13		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-225	Social Service	17		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-48	Medical Supplies Charged to Patients	71		37.10
37.11	PATIENT TELEPHONE	A	-6,079	Employee Benefits Department	4		37.11
37.12	PATIENT TELEPHONE	A	-50,219	Administrative & General	5		37.12
37.13	PATIENT TELEVISION	A	-7,514	Cap Rel Costs-Mvble Equip	2	9	37.13
37.14	PATIENT TELEVISION	A	-6,166	Administrative & General	5		37.14
37.15	PRINTING	A	-4,313	Administrative & General	5		37.15
37.16	PRINTING	A	-32	Operation of Plant	7		37.16
37.17	LOBBYING EXPENSE	A	-1,008	Administrative & General	5		37.17
37.18	MISCELLANEOUS INCOME	B	-32,322	Administrative & General	5		37.18
37.19	MISCELLANEOUS INCOME	B	-8,460	Dietary	10		37.19
37.20	PATIENT TRANSPORTATION	A	-131,533	Operation of Plant	7		37.20
37.21	MISC. TAX	A	-1,106,716	Administrative & General	5		37.21
37.22	PROFESSIONAL FEES	A	-9,867	Administrative & General	5		37.22
37.23	ADJUST MD FEES FROM 30J	A	-1,500	Administrative & General	5		37.23
38							38
39							39
40							40
41							41
42							42
43							43

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-826,765			50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
 A. Costs - if cost, including applicable overhead, can be determined
 B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		702,634	-702,634		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	86,515		86,515	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	191,629		191,629	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,520,443		1,520,443		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	192,171		192,171		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,842	1,842		10	3.03
3.04	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,842,985	1,842,985			3.04
3.05	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,698,340	2,698,340			3.05
3.06	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	16,297	16,297			3.06
3.07	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	108	108			3.07
3.08	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-7,365	-7,365			3.08
3.09	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	253	253			3.09
3.10	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	66	66			3.10
3.11	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,205	1,205			3.11
3.12	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-19	-19			3.12
3.13	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-46	-46			3.13
3.14	65	Respiratory Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	102	102			3.14
3.15	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	978	978			3.15
3.16	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	98,654	98,654			3.16
3.17	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	471,158	471,158			3.17
3.18	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,948	5,948		11	3.18
3.19	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - GROUND LEASE		177,702	-177,702	10	3.19
3.20	5	Administrative & General	RELATED PARTY - RMH	4,749	11,078	-6,329		3.20
3.21	30	Adults & Pediatrics	RELATED PARTY - RMH	105,950	105,950			3.21
3.22	54	Radiology-Diagnostic	RELATED PARTY - RMH	7,689	12,210	-4,521		3.22
3.23	54.01	RADIOLOGY-SUA	RELATED PARTY - RMH	8,076	12,826	-4,750		3.23
3.24	60	Laboratory	RELATED PARTY - RMH	284,242	658,268	-374,026		3.24
3.25	76.02	SPECIAL PROCEDURES - SUA	RELATED PARTY - RMH	5,773	5,773			3.25
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		7,537,743	6,816,947	720,796		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		50.00	ENCOMPASS HEALTH CORPORATION		HEALTHCARE	6

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS**WORKSHEET A-8-1****B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	

7	B		50.00	ROCKFORD HEALTH SYSTEM VENTURE		HEALTHCARE	7
8	G	ENCOMPASS HEALTH CORPORATION				HEALTHCARE	8
9	G	ROCKFORD HEALTH SYSTEM				HEALTHCARE	9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial Or non-financial) specify: FINANCIAL

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	50,550		50,550	211,500	353	35,894	1,795	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	50,550		50,550		353	35,894	1,795	200

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE					35,894	14,656	14,656	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					35,894	14,656	14,656	200

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,309,521	1,309,521					1
2	Cap Rel Costs-Mvble Equip	553,508		553,508				2
4	Employee Benefits Department	2,623,185			2,623,185			4
5	Administrative & General	4,857,181	27,102	11,455	410,708	5,306,446	5,306,446	5
6	Maintenance & Repairs							6
7	Operation of Plant	672,656	357,546	151,128	51,848	1,233,178	368,977	7
8	Laundry & Linen Service	138,664	6,804	2,876		148,344	44,386	8
9	Housekeeping	175,598	8,837	3,735	23,562	211,732	63,352	9
10	Dietary	732,961	70,129	29,642	78,097	910,829	272,527	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	750,173	34,704	14,669	156,043	955,589	285,920	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	91,376	11,631	4,916	19,066	126,989	37,996	16
17	Social Service	402,072	8,742	3,695	81,789	496,298	148,496	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,401,658	463,732	196,009	1,020,637	7,082,036	2,119,009	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	78,776	1,520	643		80,939	24,218	54
54.01	RADIOLOGY-SUA	95,440				95,440		54.01
60	Laboratory	531,920				531,920	159,155	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	362,107	8,229	3,478	72,911	446,725	133,664	65
66	Physical Therapy	1,328,814	123,249	52,095	272,152	1,776,310	531,486	66
67	Occupational Therapy	1,109,956	144,630	61,132	231,916	1,547,634	463,064	67
68	Speech Pathology	379,064	5,321	2,249	78,424	465,058	139,149	68
71	Medical Supplies Charged to Patients	409,074	10,358	4,378	6,065	429,875	128,622	71
73	Drugs Charged to Patients	1,007,990	11,897	5,029	94,830	1,119,746	335,037	73
76.01	SPECIAL PROCEDURES	3,883				3,883	1,162	76.01
76.02	SPECIAL PROCEDURES - SUA	1,851				1,851		76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	23,017,428	1,294,431	547,129	2,598,048	22,970,822	5,256,220	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		14,178	5,993		20,171	6,035	192
194	NRCC MARKETING	121,259	912	386	25,137	147,694	44,191	194
194.01	NRCC GUEST MEALS							194.01
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	23,138,687	1,309,521	553,508	2,623,185	23,138,687	5,306,446	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,602,155						7
8	Laundry & Linen Service	11,786	204,516					8
9	Housekeeping	15,309		290,393				9
10	Dietary	121,485		22,398	1,327,239			10
11	Cafeteria				45,265	45,265		11
12	Maintenance of Personnel							12
13	Nursing Administration	60,117		11,084		3,430	1,316,140	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	20,149		3,715		419		16
17	Social Service	15,144		2,792		1,798		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	803,318	204,516	148,107	1,238,253	22,440	1,316,140	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	2,634		486				54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	14,256		2,628		1,603		65
66	Physical Therapy	213,504		39,364		5,982		66
67	Occupational Therapy	250,542		46,192		5,098		67
68	Speech Pathology	9,218		1,700		1,724		68
71	Medical Supplies Charged to Patients	17,943		3,308		133		71
73	Drugs Charged to Patients	20,610		3,800		2,085		73
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,576,015	204,516	285,574	1,283,518	44,712	1,316,140	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	24,560		4,528				192
194	NRCC MARKETING	1,580		291		553		194
194.01	NRCC GUEST MEALS				43,721			194.01
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,602,155	204,516	290,393	1,327,239	45,265	1,316,140	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	189,268						16
17	Social Service		664,528					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	89,245	664,528	13,687,592		13,687,592		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	907		109,184		109,184		54
54.01	RADIOLOGY-SUA			95,440		95,440		54.01
60	Laboratory	9,184		700,259		700,259		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,575		603,451		603,451		65
66	Physical Therapy	25,430		2,592,076		2,592,076		66
67	Occupational Therapy	22,720		2,335,250		2,335,250		67
68	Speech Pathology	6,097		622,946		622,946		68
71	Medical Supplies Charged to Patients	6,421		586,302		586,302		71
73	Drugs Charged to Patients	24,636		1,505,914		1,505,914		73
76.01	SPECIAL PROCEDURES	53		5,098		5,098		76.01
76.02	SPECIAL PROCEDURES - SUA			1,851		1,851		76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	189,268	664,528	22,845,363		22,845,363		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			55,294		55,294		192
194	NRCC MARKETING			194,309		194,309		194
194.01	NRCC GUEST MEALS			43,721		43,721		194.01
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	189,268	664,528	23,138,687		23,138,687		202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		27,102	11,455	38,557	38,557		5
6	Maintenance & Repairs							6
7	Operation of Plant		357,546	151,128	508,674	2,681	511,355	7
8	Laundry & Linen Service		6,804	2,876	9,680	322	3,762	8
9	Housekeeping		8,837	3,735	12,572	460	4,886	9
10	Dietary		70,129	29,642	99,771	1,980	38,774	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		34,704	14,669	49,373	2,077	19,187	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		11,631	4,916	16,547	276	6,431	16
17	Social Service		8,742	3,695	12,437	1,079	4,834	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		463,732	196,009	659,741	15,399	256,391	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		1,520	643	2,163	176	841	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory					1,156		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		8,229	3,478	11,707	971	4,550	65
66	Physical Therapy		123,249	52,095	175,344	3,862	68,144	66
67	Occupational Therapy		144,630	61,132	205,762	3,365	79,965	67
68	Speech Pathology		5,321	2,249	7,570	1,011	2,942	68
71	Medical Supplies Charged to Patients		10,358	4,378	14,736	935	5,727	71
73	Drugs Charged to Patients		11,897	5,029	16,926	2,434	6,578	73
76.01	SPECIAL PROCEDURES					8		76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,294,431	547,129	1,841,560	38,192	503,012	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		14,178	5,993	20,171	44	7,839	192
194	NRCC MARKETING		912	386	1,298	321	504	194
194.01	NRCC GUEST MEALS							194.01
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,309,521	553,508	1,863,029	38,557	511,355	202

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	13,764						8
9	Housekeeping		17,918					9
10	Dietary		1,382	141,907				10
11	Cafeteria			4,840	4,840			11
12	Maintenance of Personnel							12
13	Nursing Administration		684		367	71,688		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		229		45		23,528	16
17	Social Service		172		192			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,764	9,140	132,392	2,397	71,688	11,087	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		30				113	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory						1,142	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		162		172		569	65
66	Physical Therapy		2,429		640		3,163	66
67	Occupational Therapy		2,850		546		2,826	67
68	Speech Pathology		105		185		758	68
71	Medical Supplies Charged to Patients		204		14		799	71
73	Drugs Charged to Patients		234		223		3,064	73
76.01	SPECIAL PROCEDURES						7	76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	13,764	17,621	137,232	4,781	71,688	23,528	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		279					192
194	NRCC MARKETING		18		59			194
194.01	NRCC GUEST MEALS			4,675				194.01
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	13,764	17,918	141,907	4,840	71,688	23,528	202

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		17	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	18,714						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	18,714	1,190,713		1,190,713			30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		3,323		3,323			54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		2,298		2,298			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		18,131		18,131			65
66	Physical Therapy		253,582		253,582			66
67	Occupational Therapy		295,314		295,314			67
68	Speech Pathology		12,571		12,571			68
71	Medical Supplies Charged to Patients		22,415		22,415			71
73	Drugs Charged to Patients		29,459		29,459			73
76.01	SPECIAL PROCEDURES		15		15			76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	18,714	1,827,821		1,827,821			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		28,333		28,333			192
194	NRCC MARKETING		2,200		2,200			194
194.01	NRCC GUEST MEALS		4,675		4,675			194.01
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	18,714	1,863,029		1,863,029			202

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	68,903						1
2	Cap Rel Costs-Mvble Equip		68,903					2
4	Employee Benefits Department			12,494,708				4
5	Administrative & General	1,426	1,426	1,956,275	-5,306,446	17,734,950		5
6	Maintenance & Repairs							6
7	Operation of Plant	18,813	18,813	246,959		1,233,178	48,664	7
8	Laundry & Linen Service	358	358			148,344	358	8
9	Housekeeping	465	465	112,228		211,732	465	9
10	Dietary	3,690	3,690	371,989		910,829	3,690	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,826	1,826	743,259		955,589	1,826	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	612	612	90,814		126,989	612	16
17	Social Service	460	460	389,576		496,298	460	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	24,400	24,400	4,861,500		7,082,036	24,400	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	80	80			80,939	80	54
54.01	RADIOLOGY-SUA				-95,440			54.01
60	Laboratory					531,920		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	433	433	347,286		446,725	433	65
66	Physical Therapy	6,485	6,485	1,296,307		1,776,310	6,485	66
67	Occupational Therapy	7,610	7,610	1,104,656		1,547,634	7,610	67
68	Speech Pathology	280	280	373,549		465,058	280	68
71	Medical Supplies Charged to Patients	545	545	28,887		429,875	545	71
73	Drugs Charged to Patients	626	626	451,691		1,119,746	626	73
76.01	SPECIAL PROCEDURES					3,883		76.01
76.02	SPECIAL PROCEDURES - SUA				-1,851			76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	68,109	68,109	12,374,976	-5,403,737	17,567,085	47,870	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	746	746			20,171	746	192
194	NRCC MARKETING	48	48	119,732		147,694	48	194
194.01	NRCC GUEST MEALS							194.01
194.10	OTHER NRCC							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,309,521	553,508	2,623,185		5,306,446	1,602,155	202
203	Unit Cost Multiplier (Wkst. B, Part I)	19.005283	8.033148	0.209944		0.299208	32.922797	203
204	Cost to be allocated (Per Wkst. B, Part II)					38,557	511,355	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.002174	10.507870	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA GROSS SALARIES	NURSING ADMINIS- TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY TIME SPENT	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	19,523						8
9	Housekeeping		47,841					9
10	Dietary		3,690	62,778				10
11	Cafeteria			2,141	9,807,257			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,826		743,259	19,523		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		612		90,814		43,192,710	16
17	Social Service		460		389,576			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,523	24,400	58,569	4,861,500	19,523	20,367,076	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		80				206,966	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory						2,095,813	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		433		347,286		1,043,948	65
66	Physical Therapy		6,485		1,296,307		5,803,392	66
67	Occupational Therapy		7,610		1,104,656		5,184,849	67
68	Speech Pathology		280		373,549		1,391,312	68
71	Medical Supplies Charged to Patients		545		28,887		1,465,255	71
73	Drugs Charged to Patients		626		451,691		5,622,114	73
76.01	SPECIAL PROCEDURES						11,985	76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,523	47,047	60,710	9,687,525	19,523	43,192,710	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		746					192
194	NRCC MARKETING		48		119,732			194
194.01	NRCC GUEST MEALS			2,068				194.01
194.10	OTHER NRCC							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	204,516	290,393	1,327,239	45,265	1,316,140	189,268	202
203	Unit Cost Multiplier (Wkst. B, Part I)	10.475644	6.069961	21.141785	0.004615	67.414844	0.004382	203
204	Cost to be allocated (Per Wkst. B, Part II)	13,764	17,918	141,907	4,840	71,688	23,528	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.705015	0.374532	2.260457	0.000494	3.671977	0.000545	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE						
		PATIENT DAYS						
		17						

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	19,523						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,523						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,523						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	NRCC MARKETING							194
194.01	NRCC GUEST MEALS							194.01
194.10	OTHER NRCC							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	664,528						202
203	Unit Cost Multiplier (Wkst. B, Part I)	34.038211						203
204	Cost to be allocated (Per Wkst. B, Part II)	18,714						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.958562						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	13,687,592		13,687,592	14,656	13,702,248	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	109,184		109,184		109,184	54
54.01	RADIOLOGY-SUA	95,440		95,440		95,440	54.01
60	Laboratory	700,259		700,259		700,259	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	603,451		603,451		603,451	65
66	Physical Therapy	2,592,076		2,592,076		2,592,076	66
67	Occupational Therapy	2,335,250		2,335,250		2,335,250	67
68	Speech Pathology	622,946		622,946		622,946	68
71	Medical Supplies Charged to Patients	586,302		586,302		586,302	71
73	Drugs Charged to Patients	1,505,914		1,505,914		1,505,914	73
76.01	SPECIAL PROCEDURES	5,098		5,098		5,098	76.01
76.02	SPECIAL PROCEDURES - SUA	1,851		1,851		1,851	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	22,845,363		22,845,363	14,656	22,860,019	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	22,845,363		22,845,363		22,860,019	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	20,367,076		20,367,076				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	206,966		206,966	0.527546	0.527546	0.527546	54
54.01	RADIOLOGY-SUA	217,431		217,431	0.438944	0.438944	0.438944	54.01
60	Laboratory	2,095,813		2,095,813	0.334123	0.334123	0.334123	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,043,948		1,043,948	0.578047	0.578047	0.578047	65
66	Physical Therapy	5,803,392		5,803,392	0.446648	0.446648	0.446648	66
67	Occupational Therapy	5,184,849		5,184,849	0.450399	0.450399	0.450399	67
68	Speech Pathology	1,391,312		1,391,312	0.447740	0.447740	0.447740	68
71	Medical Supplies Charged to Patients	1,465,255		1,465,255	0.400136	0.400136	0.400136	71
73	Drugs Charged to Patients	5,622,114		5,622,114	0.267855	0.267855	0.267855	73
76.01	SPECIAL PROCEDURES	11,985		11,985	0.425365	0.425365	0.425365	76.01
76.02	SPECIAL PROCEDURES - SUA	5,715		5,715	0.323885	0.323885	0.323885	76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	43,415,856		43,415,856				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	43,415,856		43,415,856				202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	13,687,592		13,687,592	14,656	13,702,248	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	109,184		109,184		109,184	54
54.01	RADIOLOGY-SUA	95,440		95,440		95,440	54.01
60	Laboratory	700,259		700,259		700,259	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	603,451		603,451		603,451	65
66	Physical Therapy	2,592,076		2,592,076		2,592,076	66
67	Occupational Therapy	2,335,250		2,335,250		2,335,250	67
68	Speech Pathology	622,946		622,946		622,946	68
71	Medical Supplies Charged to Patients	586,302		586,302		586,302	71
73	Drugs Charged to Patients	1,505,914		1,505,914		1,505,914	73
76.01	SPECIAL PROCEDURES	5,098		5,098		5,098	76.01
76.02	SPECIAL PROCEDURES - SUA	1,851		1,851		1,851	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	22,845,363		22,845,363	14,656	22,860,019	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	22,845,363		22,845,363	14,656	22,860,019	202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	20,367,076		20,367,076				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	206,966		206,966	0.527546	0.527546	0.527546	54
54.01	RADIOLOGY-SUA	217,431		217,431	0.438944	0.438944	0.438944	54.01
60	Laboratory	2,095,813		2,095,813	0.334123	0.334123	0.334123	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,043,948		1,043,948	0.578047	0.578047	0.578047	65
66	Physical Therapy	5,803,392		5,803,392	0.446648	0.446648	0.446648	66
67	Occupational Therapy	5,184,849		5,184,849	0.450399	0.450399	0.450399	67
68	Speech Pathology	1,391,312		1,391,312	0.447740	0.447740	0.447740	68
71	Medical Supplies Charged to Patients	1,465,255		1,465,255	0.400136	0.400136	0.400136	71
73	Drugs Charged to Patients	5,622,114		5,622,114	0.267855	0.267855	0.267855	73
76.01	SPECIAL PROCEDURES	11,985		11,985	0.425365	0.425365	0.425365	76.01
76.02	SPECIAL PROCEDURES - SUA	5,715		5,715	0.323885	0.323885	0.323885	76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	43,415,856		43,415,856				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	43,415,856		43,415,856				202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic	109,184	3,323	105,861		54
54.01	RADIOLOGY-SUA	95,440		95,440		54.01
60	Laboratory	700,259	2,298	697,961		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	603,451	18,131	585,320		65
66	Physical Therapy	2,592,076	253,582	2,338,494		66
67	Occupational Therapy	2,335,250	295,314	2,039,936		67
68	Speech Pathology	622,946	12,571	610,375		68
71	Medical Supplies Charged to Patients	586,302	22,415	563,887		71
73	Drugs Charged to Patients	1,505,914	29,459	1,476,455		73
76.01	SPECIAL PROCEDURES	5,098	15	5,083		76.01
76.02	SPECIAL PROCEDURES - SUA	1,851		1,851		76.02
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency					101
113	Interest Expense					113
200	Subtotal	9,157,771	637,108	8,520,663		200
201	Less Observation Beds					201
202	Total	9,157,771	637,108	8,520,663		202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic		109,184	206,966	0.527546	54
54.01	RADIOLOGY-SUA		95,440	217,431	0.438944	54.01
60	Laboratory		700,259	2,095,813	0.334123	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		603,451	1,043,948	0.578047	65
66	Physical Therapy		2,592,076	5,803,392	0.446648	66
67	Occupational Therapy		2,335,250	5,184,849	0.450399	67
68	Speech Pathology		622,946	1,391,312	0.447740	68
71	Medical Supplies Charged to Patients		586,302	1,465,255	0.400136	71
73	Drugs Charged to Patients		1,505,914	5,622,114	0.267855	73
76.01	SPECIAL PROCEDURES		5,098	11,985	0.425365	76.01
76.02	SPECIAL PROCEDURES - SUA		1,851	5,715	0.323885	76.02
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency					101
113	Interest Expense					113
200	Subtotal		9,157,771	23,048,780		200
201	Less Observation Beds					201
202	Total		9,157,771	23,048,780		202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ PARHM Demonstration

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,190,713		1,190,713	19,523	60.99	10,220	623,318	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,190,713		1,190,713	19,523		10,220	623,318	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART II

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
PARHM Demo

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	3,323	206,966	0.016056	103,855	1,667	54
54.01	RADIOLOGY-SUA		217,431		109,094		54.01
60	Laboratory	2,298	2,095,813	0.001096	1,213,112	1,330	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,131	1,043,948	0.017368	563,199	9,782	65
66	Physical Therapy	253,582	5,803,392	0.043695	3,030,264	132,407	66
67	Occupational Therapy	295,314	5,184,849	0.056957	2,735,794	155,823	67
68	Speech Pathology	12,571	1,391,312	0.009035	699,939	6,324	68
71	Medical Supplies Charged to Pat	22,415	1,465,255	0.015298	802,147	12,271	71
73	Drugs Charged to Patients	29,459	5,622,114	0.005240	3,049,431	15,979	73
76.01	SPECIAL PROCEDURES	15	11,985	0.001252	11,985	15	76.01
76.02	SPECIAL PROCEDURES - SUA		5,715		5,715		76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	637,108	23,048,780		12,324,535	335,598	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V

☒ Title XVIII, Part A

☐ Title XIX

☒ Hospital

☐ PARHM Demonstration

☒ PPS

☐ TEFRA

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V

☒ Title XVIII, Part A

☐ Title XIX

☒ Hospital

☐ PARHM Demonstration

☒ PPS

☐ TEFRA

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	19,523		10,220		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	19,523		10,220		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA									54.01
60	Laboratory									60
62.30	BLOOD CLOTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76.01	SPECIAL PROCEDURES									76.01
76.02	SPECIAL PROCEDURES - SUA									76.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	206,966			103,855				54
54.01	RADIOLOGY-SUA	217,431			109,094				54.01
60	Laboratory	2,095,813			1,213,112				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,043,948			563,199				65
66	Physical Therapy	5,803,392			3,030,264				66
67	Occupational Therapy	5,184,849			2,735,794				67
68	Speech Pathology	1,391,312			699,939				68
71	Medical Supplies Charged to Pat	1,465,255			802,147				71
73	Drugs Charged to Patients	5,622,114			3,049,431				73
76.01	SPECIAL PROCEDURES	11,985			11,985				76.01
76.02	SPECIAL PROCEDURES - SUA	5,715			5,715				76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	23,048,780			12,324,535				200

(A) Worksheet A line numbers

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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WORKSHEET D
PART V

		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim- bursed Services (see inst.)	Cost Reim- bursed Subject to Ded. & Coins. (see inst.)	Cost Reim- bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim- bursed Subject to Ded. & Coins. (see inst.)	Cost Reim- bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.527546							54
54.01	RADIOLOGY-SUA	0.438944							54.01
60	Laboratory	0.334123							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.578047							65
66	Physical Therapy	0.446648							66
67	Occupational Therapy	0.450399							67
68	Speech Pathology	0.447740							68
71	Medical Supplies Charged to Pat	0.400136							71
73	Drugs Charged to Patients	0.267855							73
76.01	SPECIAL PROCEDURES	0.425365							76.01
76.02	SPECIAL PROCEDURES - SUA	0.323885							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

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Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ PARHM Demonstration

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,190,713		1,190,713	19,523	60.99	381	23,237	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,190,713		1,190,713	19,523		381	23,237	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART II

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
PARHM Demo

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	3,323	206,966	0.016056	6,405	103	54
54.01	RADIOLOGY-SUA		217,431				54.01
60	Laboratory	2,298	2,095,813	0.001096	41,764	46	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,131	1,043,948	0.017368	20,315	353	65
66	Physical Therapy	253,582	5,803,392	0.043695	115,595	5,051	66
67	Occupational Therapy	295,314	5,184,849	0.056957	106,607	6,072	67
68	Speech Pathology	12,571	1,391,312	0.009035	22,485	203	68
71	Medical Supplies Charged to Pat	22,415	1,465,255	0.015298	19,740	302	71
73	Drugs Charged to Patients	29,459	5,622,114	0.005240	85,411	448	73
76.01	SPECIAL PROCEDURES	15	11,985	0.001252			76.01
76.02	SPECIAL PROCEDURES - SUA		5,715				76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	637,108	23,048,780		418,322	12,578	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ PARHM Demonstration

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ PARHM Demonstration

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	19,523		381		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	19,523		381		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART IV

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
Boxes: ☒ Title XIX ☐ IRF ☐ NF ☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA									54.01
60	Laboratory									60
62.30	BLOOD CLOTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76.01	SPECIAL PROCEDURES									76.01
76.02	SPECIAL PROCEDURES - SUA									76.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART IV

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
Boxes: ☒ Title XIX ☐ IRF ☐ NF ☒ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	206,966			6,405				54
54.01	RADIOLOGY-SUA	217,431							54.01
60	Laboratory	2,095,813			41,764				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,043,948			20,315				65
66	Physical Therapy	5,803,392			115,595				66
67	Occupational Therapy	5,184,849			106,607				67
68	Speech Pathology	1,391,312			22,485				68
71	Medical Supplies Charged to Pat	1,465,255			19,740				71
73	Drugs Charged to Patients	5,622,114			85,411				73
76.01	SPECIAL PROCEDURES	11,985							76.01
76.02	SPECIAL PROCEDURES - SUA	5,715							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	23,048,780			418,322				200

(A) Worksheet A line numbers

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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WORKSHEET D
PART V

		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim- bursed Services (see inst.)	Cost Reim- bursed Subject to Ded. & Coins. (see inst.)	Cost Reim- bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim- bursed Subject to Ded. & Coins. (see inst.)	Cost Reim- bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.527546							54
54.01	RADIOLOGY-SUA	0.438944							54.01
60	Laboratory	0.334123							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.578047							65
66	Physical Therapy	0.446648							66
67	Occupational Therapy	0.450399							67
68	Speech Pathology	0.447740							68
71	Medical Supplies Charged to Pat	0.400136							71
73	Drugs Charged to Patients	0.267855							73
76.01	SPECIAL PROCEDURES	0.425365							76.01
76.02	SPECIAL PROCEDURES - SUA	0.323885							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

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Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-3028****WORKSHEET D-1
PART I**

Check	☐ Title V - I/P	☒ Hospital	☐ SUB (Other)	☐ ICF/IID	☒ PPS
Applicable	☒ Title XVIII, Part A	☐ IPF	☐ SNF	☐ PARHM Demo	☐ TEFRA
Boxes:	☐ Title XIX - I/P	☐ IRF	☐ NF		☐ Other

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,523	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,523	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,523	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	10,220	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	13,702,248	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,702,248	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,702,248	37

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1 PART II

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ PARHM Demo ☐ TEFRA
Boxes: ☐ Title XIX - I/P ☐ IRF ☐ Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						701.85 38
39	Program general inpatient routine service cost (line 9 x line 38)						7,172,907 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						7,172,907 41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						4,877,331 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						12,050,238 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						623,318 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						335,598 51
52	Total Program excludable cost (sum of lines 50 and 51)						958,916 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						11,091,322 53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PARHM Demo

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					701.85	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-3028****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☐ **PPS**
Applicable ☐ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **PARHM Demo** ☐ **TEFRA**
Boxes: ☒ **Title XIX - I/P** ☐ **IRF** ☐ **NF** ☐ **[XX] Other**

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,523	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,523	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,523	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	381	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	13,687,592	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,687,592	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,687,592	37

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1 PART II

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ PPS
Applicable ☐ Title XVIII, Part A ☐ IPF ☐ PARHM Demo ☐ TEFRA
Boxes: ☒ Title XIX - I/P ☐ IRF ☒ Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						701.10 38
39	Program general inpatient routine service cost (line 9 x line 38)						267,119 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						267,119 41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						169,566 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						436,685 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						23,237 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						12,578 51
52	Total Program excludable cost (sum of lines 50 and 51)						35,815 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P
☐ Title XVIII, Part A
☒ Title XIX - I/P

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID
PARHM Demo

☐ PPS
☐ TEFRA
☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					701.85	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-3028

WORKSHEET D-3

Check ☐ Title V ☒ Hospital ☐ SNF ☐ ICF/IID ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ NF ☐ PARHM Demo ☐ TEFRA
 Boxes: ☐ Title XIX ☐ IRF ☐ Swing Bed SNF ☐ PARHM CAH ☐ Other
☐ SUB (Other) ☐ Swing Bed NF

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		10,655,017		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.527546	103,855	54,788	54
54.01	RADIOLOGY-SUA	0.438944	109,094	47,886	54.01
60	Laboratory	0.334123	1,213,112	405,329	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.578047	563,199	325,555	65
66	Physical Therapy	0.446648	3,030,264	1,353,461	66
67	Occupational Therapy	0.450399	2,735,794	1,232,199	67
68	Speech Pathology	0.447740	699,939	313,391	68
71	Medical Supplies Charged to Patients	0.400136	802,147	320,968	71
73	Drugs Charged to Patients	0.267855	3,049,431	816,805	73
76.01	SPECIAL PROCEDURES	0.425365	11,985	5,098	76.01
76.02	SPECIAL PROCEDURES - SUA	0.323885	5,715	1,851	76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		12,324,535	4,877,331	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		12,324,535		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-3028

WORKSHEET D-3

Check ☐ Title V ☒ Hospital ☐ SNF ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ NF ☐ PARHM Demo ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ Swing Bed SNF ☐ PARHM CAH ☒ Other
☐ SUB (Other) ☐ Swing Bed NF

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		397,764		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.527546	6,405	3,379	54
54.01	RADIOLOGY-SUA	0.438944			54.01
60	Laboratory	0.334123	41,764	13,954	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.578047	20,315	11,743	65
66	Physical Therapy	0.446648	115,595	51,630	66
67	Occupational Therapy	0.450399	106,607	48,016	67
68	Speech Pathology	0.447740	22,485	10,067	68
71	Medical Supplies Charged to Patients	0.400136	19,740	7,899	71
73	Drugs Charged to Patients	0.267855	85,411	22,878	73
76.01	SPECIAL PROCEDURES	0.425365			76.01
76.02	SPECIAL PROCEDURES - SUA	0.323885			76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		418,322	169,566	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		418,322		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-3028****WORKSHEET E
PART B**

Check applicable box: ☒ Hospital ☐ IPF ☐ IRF ☐ SUB (Other) ☐ SNF ☐ PARHM Demonstration

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
40.03	Sequestration adjustment - PARHM pass-throughs				40.03
41	Interim payments				41
41.01	Interim payments - PARHM				41.01
42	Tentative settlement (for contractors use only)				42
42.01	Tentative settlement - PARHM (for contractor use only)				42.01
43	Balance due provider/program (see instructions)				43
43.01	Balance due provider/program - PARHM (see instructions)				43.01
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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WORKSHEET E-1
PART I

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[ ] PARHM Demonstration
[ ] PARHM CAH Swing Bed-SNF
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(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-3028

WORKSHEET E-3
PART III

Check [XX] Hospital
Applicable [] Subprovider IRF
Box:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	16,532,027		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.036300		2
3	Inpatient Rehabilitation LIP payments (see instructions)	945,632		3
4	Outlier payments	54,404		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	53.341530		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	17,532,063		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	17,532,063		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	17,532,063		19
20	Deductibles	168,564		20
21	Subtotal (line 19 minus line 20)	17,363,499		21
22	Coinsurance	95,392		22
23	Subtotal (line 21 minus line 22)	17,268,107		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	68,322		24
25	Adjusted reimbursable bad debts (see instructions)	44,409		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,594		26
27	Subtotal (sum of lines 23 and 25)	17,312,516		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	17,312,516		32
32.01	Sequestration adjustment (see instructions)	114,263		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	17,074,389		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	123,864		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	464,770		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)			50
51	Outlier reconciliation adjustment amount (see instructions)			51
52	The rate used to calculate the Time Value of Money (see instructions)			52
53	Time Value of Money (see instructions)			53

Health Financial Systems Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-3028

WORKSHEET E-3
PART VII

Check ☐ Title V ☒ Hospital ☐ NF ☐ PPS
Applicable ☒ Title XIX ☐ SUB (Other) ☐ ICF/IID ☐ TEFRA
Boxes: ☐ SNF ☒ Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	436,685		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	436,685		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	436,685		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	397,764		8
9	Ancillary service charges	418,322		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	816,086		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	816,086		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	379,401		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	436,685		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	436,685		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	436,685		31
32	Deductibles			32
33	Coinsurance	108,811		33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	327,874		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	327,874		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	327,874		40
41	Interim payments	367,228		41
42	Balance due provider/program (line 40 minus line 41)	-39,354		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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BALANCE SHEET

WORKSHEET G

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	7,442,153				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	5,568,579				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,459,162				6
7	Inventory	74,627				7
8	Prepaid expenses	243,824				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	11,870,021				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	16,978,773				15
16	Accumulated depreciation	-9,617,388				16
17	Leasehold improvements	940,037				17
18	Accumulated depreciation	-527,475				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	6,628,812				23
24	Accumulated depreciation	-2,665,682				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	11,737,077				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	3,275,836				34
35	Total other assets (sum of lines 31-34)	3,275,836				35
36	Total assets (sum of lines 11, 30 and 35)	26,882,934				36
	Liabilities and Fund Balances (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	772,340				37
38	Salaries, wages and fees payable	1,260,061				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	853,732				44
45	Total current liabilities (sum of lines 37 thru 44)	2,886,133				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	12,525,432				49
50	Total long term liabilities (sum of lines 46 thru 49)	12,525,432				50
51	Total liabilities (sum of lines 45 and 50)	15,411,565				51
	CAPITAL ACCOUNTS					
52	General fund balance	11,471,369				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	11,471,369				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	26,882,934				60

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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STATEMENT OF CHANGES IN FUND BALANCES**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		8,737,292			1
2	Net income (loss) (from Worksheet G-3, line 29)		5,971,990			2
3	Total (sum of line 1 and line 2)		14,709,282			3
4	Additions (credit adjustments) (specify)					4
5	EQUITY ADDITION	242,018				5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		242,018			10
11	Subtotal (line 3 plus line 10)		14,951,300			11
12	Deductions (debit adjustments) (specify)					12
13	DEDUCTION	3,479,931				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		3,479,931			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,471,369			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	EQUITY ADDITION					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	DEDUCTION					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	20,367,076		20,367,076	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	20,367,076		20,367,076	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	20,367,076		20,367,076	17
18	Ancillary services	23,048,780		23,048,780	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	43,415,856		43,415,856	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		23,965,452	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		23,965,452	43

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2020 To: 12/31/2020	Run Date: 05/14/2021 Run Time: 15:16 Version: 2020.06 (04/13/2021)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	43,415,856	1
2	Less contractual allowances and discounts on patients' accounts	14,741,107	2
3	Net patient revenues (line 1 minus line 2)	28,674,749	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	23,965,452	4
5	Net income from service to patients (line 3 minus line 4)	4,709,297	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	18,586	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	16	10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	9,952	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen	39	20
21	Rental of vending machines		21
22	Rental of hosptial space	19,414	22
23	Governmental appropriations		23
24	Other (specify)	1,214,686	24
24.50	COVID-19 PHE FUNDING		24.50
25	Total other income (sum of lines 6-24)	1,262,693	25
26	Total (line 5 plus line 25)	5,971,990	26
29	Net income (or loss) for the period (line 26 minus line 28)	5,971,990	29